

Twelve Step Facilitation Therapy

Date of Review: January 2008

Twelve Step Facilitation Therapy (TSF) is a brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse, alcoholism, and other drug abuse and addiction problems. TSF is implemented with individual clients over 12 to 15 sessions. The intervention is based on the behavioral, spiritual, and cognitive principles of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These principles include acknowledging that willpower alone cannot achieve sustained sobriety, that surrender to the group conscience must replace self-centeredness, and that long-term recovery consists of a process of spiritual renewal. Therapy focuses on two general goals: (1) acceptance of the need for abstinence from alcohol and other drug use and (2) surrender, or the willingness to participate actively in 12-step fellowships as a means of sustaining sobriety. The TSF counselor assesses the client's alcohol or drug use, advocates abstinence, explains the basic 12-step concepts, and actively supports and facilitates initial involvement and ongoing participation in AA. The counselor also discusses specific readings from the AA/NA literature with the client, aids the client in using AA/NA resources in crisis times, and presents more advanced concepts such as moral inventories.

The Twelve Step Facilitation manual reviewed for this summary incorporates material originally developed for Project MATCH, an 8-year, national clinical trial of alcoholism treatment matching funded by the National Institute on Alcohol Abuse and Alcoholism. Project MATCH included two independent but parallel matching study arms, one with clients recruited from outpatient settings, the other with patients receiving aftercare treatment following inpatient care. Patients were randomly assigned to Twelve Step Facilitation, Cognitive-Behavioral Therapy, or Motivational Enhancement Therapy. Findings from Project MATCH are included in this summary.

Descriptive Information

Areas of Interest	Substance abuse treatment
Outcomes	1: Percentage of days abstinent from alcohol 2: Adverse consequences of drinking 3: Combined assessment of drinking and drinking problems 4: Number of days before first drink/heavy drinking ("time to event") 5: Drinks per drinking day 6: Alcoholics Anonymous involvement
Outcome Categories	Alcohol Mental health Social functioning Treatment/recovery
Ages	18-25 (Young adult) 26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	Inpatient Outpatient
Geographic Locations	Urban Suburban
Implementation History	The TSF approach has been widely used in treatment programs in all 50 States. It also has been implemented in Australia, Bermuda, Canada, Greece, Ireland, New Zealand, South Africa, Taiwan, and the United Kingdom.

NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	Client handouts are available in Spanish.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	IOM prevention categories are not applicable.

Outcomes

Outcome 1: Percentage of days abstinent from alcohol

Description of Measures	Percentage of days abstinent from alcohol, a measure of drinking frequency over the past 90 days, was obtained using Form 90, an interview procedure using the Timeline Followback methodology.
Key Findings	Toward the end of the 15-month follow-up period, TSF clients reported a significantly higher percentage of days abstinent from alcohol (i.e., fewer drinking days) than clients receiving Cognitive Behavioral Therapy (CBT) or Motivational Enhancement Therapy (MET) ($p < .001$). At 3-year follow-up, TSF clients also attained higher rates of abstinence than clients receiving CBT or MET ($p = .007$). Specifically, 36 percent of the TSF clients were abstinent during months 37 to 39, compared with 24% of the CBT and 26% of the MET clients. TSF and CBT clients with social networks supportive of drinking reported a higher percentage of days abstinent than clients receiving MET. Effect size for alcohol use during this period was large ($\eta^2 = 0.74$, $p = .0058$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.7 (0.0-4.0 scale)

Outcome 2: Adverse consequences of drinking

Description of Measures	Adverse consequences of drinking were assessed using the Drinker Inventory of Consequences (DrInC), a 50-item self-administered questionnaire designed to measure alcohol-related problems in five areas: Interpersonal, Physical, Social, Impulsive, and Intrapersonal.
Key Findings	Toward the end of the 15-month follow-up period, TSF clients reported a significantly higher percentage of days abstinent from alcohol than clients receiving Cognitive Behavioral Therapy (CBT) or Motivational Enhancement Therapy (MET; $p < .001$). At 3-year follow-up, TSF clients also attained higher rates of abstinence than clients receiving CBT or MET ($p = .007$). Specifically, 36% of the TSF clients were abstinent during months 37 to 39, compared with 24% of the CBT and 26% of the MET clients. TSF and CBT clients with social networks supportive of drinking reported a higher percentage of days abstinent than clients receiving MET ($p = .0058$). Effect size for alcohol use during this period was large ($\eta^2 = 0.74$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.5 (0.0-4.0 scale)

Outcome 3: Combined assessment of drinking and drinking problems

Description of Measures	Data on respondents' percentage of days abstinent from alcohol and adverse drinking consequences were combined to yield a single, categorical outcome measure (category 1 = no drinking; category 2 = moderate drinking and nonrecurrent problems; category 3 = heavy drinking or recurrent problems; category 4 = heavy drinking and recurrent problems).
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Key Findings	At 15-month follow-up, a higher percentage of TSF clients were shown to be in the no-drinking category (category 1) compared with clients receiving CBT or MET ($p = .0024$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.4 (0.0-4.0 scale)

Outcome 4: Number of days before first drink/heavy drinking ("time to event")

Description of Measures	Time to event was assessed using two measures on Form 90: time to first drink (number of days of abstinence preceding the occurrence of the first drink) and time to first episode of 3 consecutive days of heavy drinking (number of days of less than heavy drinking preceding 3 consecutive days of heavy drinking). Heavy drinking was defined as six or more drinks per day for men and four or more drinks per day for women.
Key Findings	For the time to first drink measure, a significantly larger proportion of clients in the TSF condition (24%) avoided drinking completely in months 4-15 than in the CBT (15%) and MET (14%) conditions ($p = .0001$). Similar results were found for time to first episode of 3 consecutive days of heavy drinking ($p = .0016$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.6 (0.0-4.0 scale)

Outcome 5: Drinks per drinking day

Description of Measures	Drinks per drinking day (number of standard units of alcohol consumed on days the respondent drank alcohol) in the past 90 days was obtained using Form 90.
Key Findings	At 3-year follow-up, TSF and CBT clients who reported having social networks supportive of drinking reported fewer drinks per drinking day compared with clients receiving MET ($p = .0035$). The effect size for this finding was large ($\eta^2 = 0.94$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.6 (0.0-4.0 scale)

Outcome 6: Alcoholics Anonymous involvement

Description of Measures	A 13-item Alcoholics Anonymous Involvement Scale (AAI) was used to measure attendance and involvement in AA. Items assessed program participation as well as commitment to the AA fellowship.
Key Findings	Among clients with social networks supportive of drinking, AA involvement was higher for TSF clients (62%) than for those receiving MET (38%) or CBT (25%).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.4 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	18-25 (Young adult) 26-55 (Adult)	75.7% Male 24.3% Female	80% White 10% Black or African American 7.9% Hispanic or Latino 2% Race/ethnicity unspecified

Quality of Research

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies.

Study 1

[Longabaugh, R., Wirtz, P. W., Zweben, A., & Stout, R. L. \(1998\). Network support for drinking, Alcoholics Anonymous and long-term matching effects. Addiction, 93\(9\), 1313-1333.](#) 

[Project MATCH Research Group. \(1997\). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. Journal of Studies on Alcohol, 58, 7-29.](#) 

[Project MATCH Research Group. \(1998\). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. Alcoholism: Clinical and Experimental Research, 22, 1300-1311.](#) 

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

- | | |
|----------------------------|------------------------------------|
| 1. Reliability of measures | 4. Missing data and attrition |
| 2. Validity of measures | 5. Potential confounding variables |
| 3. Intervention fidelity | 6. Appropriateness of analysis |

For more information about these criteria and the meaning of the ratings, see [Quality of Research](#).

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Percentage of days abstinent from alcohol	3.8	3.8	3.5	4.0	3.0	4.0	3.7
2: Adverse consequences of drinking	3.3	3.3	3.5	4.0	3.0	4.0	3.5
3: Combined assessment of drinking and drinking problems	3.0	3.0	3.5	4.0	3.0	4.0	3.4
4: Number of days before first drink/heavy drinking ("time to event")	3.8	3.3	3.5	4.0	3.0	4.0	3.6
5: Drinks per drinking day	3.5	3.5	3.5	4.0	3.3	4.0	3.6
6: Alcoholics Anonymous involvement	3.3	3.0	3.8	3.5	3.0	3.8	3.4

Study Strengths

The multisite study was large and well designed. It employed random assignment, excellent intervention fidelity and training methods, clear and well-specified treatments, sophisticated measures, and a high-quality data analytic approach.

Study Weaknesses

The study did not use a control (minimal or no treatment) condition.

Readiness for Dissemination

The documents below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Dissemination Materials

Hazelden Foundation. (2006). Introduction to twelve step groups [DVD]. Center City, MN: Hazelden Foundation.

Hazelden Foundation. (2006). Introduction to twelve step groups: Facilitator's guide. Center City, MN: Hazelden Foundation.

Nowinski, J. (2006). The Twelve Step Facilitation Outpatient Program: The Project MATCH Twelve Step Treatment Protocol. Facilitator guide. Center City, MN: Hazelden Foundation.

Nowinski, J. (2006). Twelve-step facilitation training slides.

Nowinski, J. (n.d.). Twelve-step facilitation overview.

Nowinski, J. (n.d.). Twelve-step facilitation professional training seminar.

Nowinski, J., & Baker, S. (2003). The Twelve Step Facilitation handbook: A systematic approach to recovery from substance dependence. The Project MATCH Twelve Step Treatment Protocol. Center City, MN: Hazelden Foundation.

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see [Readiness for Dissemination](#).

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.0	3.0	3.0	3.0

Dissemination Strengths

The program materials include session-by-session instructions and tips for a systematic approach to implementation. The detailed training addresses program background, structure, process, and content. A protocol for monitoring outcomes is provided to support quality assurance.

Dissemination Weaknesses

No materials are available to assist program implementers in recruiting clients or addressing organizational implementation. Ongoing coaching or consultation is not available to support implementers beyond initial training. No protocol is provided to support implementation fidelity.

Costs

The cost information below was provided by the developer. Although it may have been updated by the developer since the time of review, the information below may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Curriculum (includes the National Institute on Alcohol Abuse and Alcoholism study manual, research information, and fidelity checklist)	\$329 each	Yes
1-day, on-site basic or refresher training	\$2,200 per day per site plus travel expenses	No
1-day, off-site basic or refresher training	\$200 per participant	No
Technical assistance	\$100 per hour	No

Additional Information

The cost of implementation includes the purchase of the curriculum (which an experienced adult or adolescent treatment counselor, outpatient or inpatient treatment counselor, or mental health professional can deliver without training) and the cost of the treatment provider or private practice professional's salary. Discounts are available depending on the volume of orders. Purchasers who place orders through Hazelden's Online Bookstore receive free shipping.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Carroll, K. M., Nich, C., Ball, S. A., McCance, E., & Rounsaville, B. J. (1998). Treatment of cocaine and alcohol dependence with psychotherapy and disulfiram. *Addiction*, 93(5), 713-727. 

Glasner-Edwards, S., Tate, S. R., McQuaid, J. R., Cummins, K., Granholm, E., & Brown, S. A. (2007). Mechanisms of action in integrated cognitive-behavioral treatment versus twelve-step facilitation for substance-dependent adults with comorbid major depression. *Journal of Studies on Alcohol and Drugs*, 68, 663-672. 

Tonigan J. S. (2001). Benefits of Alcoholics Anonymous attendance: Replication of findings between clinical research sites in Project MATCH. *Alcoholism Treatment Quarterly*, 19(1), 67-78.

Contacts

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